Medica Advantage Solution® H6154-002 (HMO-POS) offered by Medica Health Plans

Annual Notice of Changes for 2023

You are currently enrolled as a member of Medica Advantage Solution H6154-002. Next year, there will be changes to the plan's costs and benefits. ***Please see page 8 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at Medica.com/MyPlanDocs. You may also call Medica Customer Service to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.
- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in our plan.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with our plan.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Medica Customer Service number at 1 (866) 269-6804 (toll-free) for additional information (TTY users should call 711). Hours are from Oct. 1 – March 31, 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday.
- This information is available in braille, large print, or other alternate formats. Please call Medica Customer Service if you need plan information in another format (phone numbers are in Section 6.1 of this document).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About our plan

- Medica is an HMO-POS plan with a Medicare contract. Enrollment in Medica depends on contract renewal.
- When this document says "we," "us," or "our", it means Medica Health Plans. When it says "plan" or "our plan," it means Medica Advantage Solution H6154-002.

MULTI-LANGUAGE INSERT

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1 (866) 745-9919.** Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1 (866) 745-9919.** Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1 (866) 745-9919**。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1 (866) 745-9919**。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1 (866) 745-9919.** Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1 (866) 745-9919.** Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1 (866) 745-9919** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1 (866) 745-9919.** Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1 (866) 745-9919** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1 (866) 745-9919.** Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة مجانية فوري، ليس عليك سوى الاتصال بنا على **1 (866) 745-9919**. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1 (866) 745-9919** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1 (866) 745-9919.** Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1 (866) 745-9919.** Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1 (866) 745-9919.** Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1 (866) 745-9919.** Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1 (866) 745-9919** にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication
- Written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages

If you need these services, contact the number on the back of your identification card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for our plan in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $5,600 From out-of-network providers: $7,500	From network providers: $5,500 From out-of-network providers: $7,500
Doctor office visits	Primary care visits: In-Network: $0 copay per visit Out-of-Network: 40% of the total cost per visit Specialist visits: In-Network: $50 copay per visit Out-of-Network: 40% of the total cost per visit	Primary care visits: In-Network: $0 copay per visit Out-of-Network: 40% of the total cost per visit Specialist visits: In-Network: $50 copay per visit Out-of-Network: 40% of the total cost per visit
Inpatient hospital stays	In-Network: $450 copay each day for days 1 through 4 and $0 copay for days 5 through 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days.	In-Network: $450 copay each day for days 1 through 4 and $0 copay for days 5 through 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days.

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays (continued)	Out-of-Network: 40% of the total cost per stay.	Out-of-Network: 40% of the total cost per stay.
Part D prescription drug coverage (See Section 1.5 for details.) To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by referring to the SSM indicator in your plan's Formulary (Drug List). If you have questions about the Drug List, you can also call Medica Customer Service (phone numbers for Medica Customer Service are printed in Section 6 of this document).	Deductible: $395 for your Tier 3, Tier 4 and Tier 5 drugs Copay/Coinsurance during the Initial Coverage Stage: **Preferred Pharmacy cost sharing:** • Drug Tier 1: $4 • Drug Tier 2: $14 • Drug Tier 3: $47 • Drug Tier 4: 50% • Drug Tier 5: 26% **Standard Pharmacy cost sharing:** • Drug Tier 1: $15 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% • Drug Tier 5: 26%	Deductible: $395 for your Tier 3, Tier 4 and Tier 5 drugs Copay/Coinsurance during the Initial Coverage Stage: **Preferred Pharmacy cost sharing:** • Drug Tier 1: $4 • Drug Tier 2: $14 • Drug Tier 3: $47 • Drug Tier 4: 50% • Drug Tier 5: 26% **Standard Pharmacy cost sharing:** • Drug Tier 1: $15 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% • Drug Tier 5: 26%

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**In-Network** $5,600	**In-Network** $5,500 Once you have paid $5,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.
	Out-of-Network $7,500	**Out-of-Network** $7,500 Once you have paid $7,500 out-of-pocket for covered Part A and Part B

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount (continued)		services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at Medica.com/MyPlanDocs. You may also call Medica Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Medica Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Dental services	Our plan provides up to $250 reimbursement for non-Medicare-covered dental services every calendar year.	Our plan provides up to $350 reimbursement for non-Medicare-covered dental services every calendar year.
Diabetic supplies	**In-Network** $0 copay for diabetic testing supplies from LifeScan™ (OneTouch®) and Roche (Accu-Chek®).	**In-Network** $0 copay for diabetic testing supplies from LifeScan™ (OneTouch®) and Roche (Accu-Chek®).

Cost	2022 (this year)	2023 (next year)
Diabetic supplies (continued)	You pay 20% of the total cost for diabetic testing supplies from non-preferred manufacturers. **Out-of-Network** $0 copay for diabetic testing supplies from LifeScan (OneTouch) and Roche (Accu-Chek). You pay 20% of the total cost for diabetic testing supplies from non-preferred manufacturers.	Diabetic testing supplies are limited to LifeScan (OneTouch) and Roche (Accu-Chek). **Out-of-Network** $0 copay for diabetic testing supplies from LifeScan (OneTouch) and Roche (Accu-Chek). Diabetic testing supplies are limited to LifeScan (OneTouch) and Roche (Accu-Chek).
Hearing services	You pay a $549 copay for each Basic level hearing aid. You pay a $799 copay for each Reserve level hearing aid. Hearing aid fitting-evaluation: Up to 3 hearing aid fittings-evaluations are available with the purchase of private label Basic or Reserve level hearing aids. You must see an EPIC Hearing provider to use this benefit. $0 copay per fitting-evaluation for a Reserve level hearing aid.	You pay a $549 copay for each Silver level hearing aid. You pay a $799 copay for each Gold level hearing aid. Hearing aid fitting-evaluation: 1 hearing aid fitting-evaluation is available with the purchase of private label Silver level hearing aids. Up to 3 hearing aid fittings-evaluations are available with the purchase of private label Gold level hearing aids. You must see an EPIC Hearing provider to use this benefit. $0 copay per fitting-evaluation for each Silver level hearing aid.

Cost	2022 (this year)	2023 (next year)
Hearing services (continued)	You pay a $50 copay per fitting-evaluation for a Basic level hearing aid.	$0 copay per fitting-evaluation for each Gold level hearing aid.
Outpatient diagnostic tests and therapeutic services and supplies - sleep studies	**In-Network** You pay 20% of the total cost for each Medicare-covered home-based and facility-based sleep study. $150 out-of-pocket maximum per day.	**In-Network** $0 copay for Medicare-covered home-based sleep studies. You pay 20% of the total cost for each Medicare-covered facility-based sleep study. $150 out-of-pocket maximum per day.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay a $395 copay for each Medicare-covered service.	**In-Network** You pay a $395 copay for each Medicare-covered service at an outpatient hospital facility. You pay a $320 copay for each Medicare-covered surgery or procedure at an ambulatory surgical center.
Physician/Practitioner services, including doctor's office visits – Certain telehealth services	**In-Network** Additional telehealth for Medicare-covered cardiac rehabilitation services is not covered.	**In-Network** You pay a $30 copay for additional telehealth for Medicare-covered cardiac rehabilitation services.
Pulmonary rehabilitation services	**In-Network** You pay a $30 copay for each Medicare-covered service.	**In-Network** You pay a $20 copay for each Medicare-covered service.
Skilled nursing facility (SNF) care	**In-Network** You pay a $0 copay for days 1 through 20 and a $184 copay each day for	**In-Network** You pay a $0 copay for days 1 through 20, a $196 copay each day for days 21 through 49, and a $0 copay for days 50 through

Cost	2022 (this year)	2023 (next year)
Skilled nursing facility (SNF) care (continued)	days 21 through 100 for Medicare-covered skilled nursing facility care.	100 for Medicare-covered skilled nursing facility care.
Supervised exercise therapy (SET)	**In-Network** You pay a $30 copay for each Medicare-covered service.	**In-Network** You pay a $25 copay for each Medicare-covered service.
Visitor/Travel benefit	You may receive all plan covered services at in-network cost sharing when temporarily and continuously absent from Minnesota for at least 1 month, but no more than 6 consecutive months. Please contact your plan to activate this benefit and provide the travel dates that you intend to be outside Minnesota.	You may receive all plan covered services at in-network cost sharing when temporarily and continuously absent from Minnesota for no more than 6 consecutive months. Please contact your plan to activate this benefit and provide the travel dates that you intend to be outside Minnesota.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions**.

We have made changes to the list of insulin drugs that will be covered as Select Insulins at a lower cost-sharing. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by referring to the SSM indicator in your plan's Formulary (Drug List). If you have questions about the Drug List, you can also call Medica Customer Service (phone numbers for Medica Customer Service are printed in Section 6 of this document).

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Medica Customer Service for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2022, please call Medica Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Medica Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact our Medica Customer Service number at 1 (866) 269-6804 (toll-free) for additional information. (TTY users should call 711.) Hours of operation are Oct. 1 – March 31, 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible.	The deductible is **$395**. During this stage, you pay: **$15** standard cost sharing or **$4** preferred cost sharing for drugs on **Tier 1**; **$20** standard cost sharing or **$14** preferred cost sharing for drugs on **Tier 2**; And the full cost of drugs on **Tier 3**, **Tier 4** and **Tier 5** until you have reached the yearly deductible.	The deductible is **$395**. During this stage, you pay: **$15** standard cost sharing or **$4** preferred cost sharing for drugs on **Tier 1**; **$20** standard cost sharing or **$14** preferred cost sharing for drugs on **Tier 2**; And the full cost of drugs on **Tier 3**, **Tier 4** and **Tier 5** until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6,	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $4 per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $20 per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $4 per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $20 per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued) Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	*Preferred cost sharing:* You pay $14 per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $47 per prescription. **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay 50% of the total cost. *Preferred cost sharing:* You pay 50% of the total cost. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 26% of the total cost. *Preferred cost sharing:* You pay 26% of the total cost. _____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	*Preferred cost sharing:* You pay $14 per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $47 per prescription. **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay 50% of the total cost. *Preferred cost sharing:* You pay 50% of the total cost. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 26% of the total cost. *Preferred cost sharing:* You pay 26% of the total cost. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in our plan

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR* -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Medica Health Plans offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Medica Customer Service if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Minnesota, the SHIP is called Minnesota Board on Aging/Senior LinkAge Line®.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Minnesota Board on Aging/Senior LinkAge Line counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Minnesota Board on Aging/Senior LinkAge Line at 1 (800) 333-2433 (toll-free). You can learn more about Minnesota Board on Aging/Senior LinkAge Line by visiting their website (www.mn.gov/board-on-aging).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- "**Extra Help**" **from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual

deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (651) 431-2414 or 1 (800) 657-3761 (toll-free).

SECTION 6 Questions?

Section 6.1 – Getting Help from our plan

Questions? We're here to help. Please call Medica Customer Service at 1 (866) 269-6804 (TTY only, call 711). We are available for phone calls from Oct. 1 – March 31, 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. Calls to these numbers are free.

Read your 2023 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the 2023 *Evidence of Coverage* for our plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at Medica.com/MyPlanDocs. You may also call Medica Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at Medica.com/Members. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.